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Advancement of women

Supporting efforts to end obstetric fistula

Report of the Secretary-General

Summary

The present report was prepared in response to General Assembly resolution 63/158. Obstetric fistula is a devastating childbirth injury that leaves women incontinent and often isolated from their communities. It is a stark example of continued poor maternal and reproductive health services and an indication of high levels of maternal death and disability. The report outlines the efforts made at the international, regional and national levels, including by the United Nations system, to end obstetric fistula. It concludes with recommendations that efforts to end obstetric fistula be intensified as part of support for the achievement of Millennium Development Goal 5, on improving maternal health, including the strengthening of health-care systems and increasing the levels and predictability of funding.

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I. Introduction

1. The present report is submitted in accordance with General Assembly resolution 63/158, in which the Assembly requested the Secretary-General to submit to it at its sixty-fifth session a report on the implementation of the resolution under the agenda item entitled "Advancement of women".

2. Reproductive health problems remain the leading cause of ill health and death for women of childbearing age worldwide. Impoverished women, in particular those in developing countries, suffer disproportionately from unintended pregnancies, maternal death and disability, sexually transmitted infections, including HIV, gender-based violence and other problems related to their reproductive system. The education and empowerment of women are crucial in preventing obstetric fistula and improving maternal health. Educated women are better able to understand the need for appropriate care during pregnancy and delivery and are more likely to be prepared to delay marriage until an appropriate age, prevent early pregnancies and exercise their reproductive health choices.

3. The present report, while outlining the main causes of obstetric fistula and the efforts of the international community and the United Nations system to address it, draws attention to the urgent need for a commitment to address the issue of obstetric fistula within the context of the broader efforts being made towards the achievement of Millennium Development Goal 5, on improving maternal health and achieving universal access to reproductive health by 2015.

II. Background

4. Obstetric fistula is one of the most devastating consequences of neglect during childbirth and a stark example of health inequity in the world. Although the condition has been eliminated in the developed world, obstetric fistula continues to afflict the most impoverished women and girls, most of whom live in rural and remote areas of the developing world. Historically, obstetric fistula has been a neglected reproductive health and human rights issue. Putting an end to obstetric fistula necessitates addressing its medical and socio-economic determinants, from access to quality maternal health services to the elimination of gender-based social and economic inequities; preventing child marriage and early childbearing; and providing equitable access to sexual and reproductive health services and basic education.

5. The main cause of obstetric fistula, namely obstructed labour, is one of the leading causes of maternal mortality in the developing world. When a woman undergoes prolonged obstructed labour without receiving timely medical and/or surgical care, typically a Caesarean section, the pressure of the baby's head can cause extensive damage to organs in her pelvis. If she survives, the woman may be left with a hole between vagina and bladder, or vagina and rectum, that constantly leaks urine and/or faeces.

6. The medical and social consequences of obstetric fistula can be life-shattering for women and their children. In almost 90 per cent of fistula cases, the baby is

stillborn or dies within the first week of life.[1] The woman is not only left with chronic leakage of urine and/or faeces, but may also experience neurological disorders and orthopaedic injury, bladder infections, painful sores, kidney failure or infertility. The smell from the constant leakage combined with misperceptions about its cause often results in stigma and ostracism by communities. Many women are abandoned by their husbands and their families and often cannot participate in daily family and community life. They may find it difficult to maintain a source of income or support, thereby deepening their poverty. Feelings of isolation may affect their mental health, resulting in depression, low self-esteem and, in some cases, suicide.

7. While precise figures are lacking, it is generally accepted that at least 2 million women, perhaps as many as 3.5 million, suffer from obstetric fistula.[2] The World Health Organization (WHO) estimates that each year approximately 50,000 to 100,000 women worldwide are affected by obstetric fistula.[3] That figure may be an underestimate, as it is based on facility data, and a significant number of the impoverished women from rural and remote areas in developing countries who experience complicated labour are likely never to reach a hospital. Obstetric fistula has the highest prevalence in sub-Saharan Africa and South Asia, where the majority of maternal deaths occur and maternal mortality ratios often exceed 250 per 100,000 live births.[4] The lifetime risk of maternal death in those regions can be 1,000 times greater than in industrialized regions, representing the greatest health inequity in the world. In Asia, Latin America, the Caribbean and the Arab States, progress has been made with regard to reducing maternal mortality, but some countries and certain populations in those regions continue to experience high rates of maternal death.

8. Obstetric fistula is almost entirely preventable when there is universal and equitable access to quality maternal and reproductive health services. The same interventions that prevent maternal mortality can also prevent maternal morbidity. Improving maternal and reproductive health has to be a country-owned and country-driven development process, in the context of the strengthening of the country's national health plan and health-care system. The current situation reflects the weakness of health-care systems, including inadequately trained human resources; the unavailability of essential medicines and medical equipment; and the lack of easy access to quality maternal and reproductive health services in many developing countries. Within the context of maternal and reproductive health, three interventions have the most important and immediate impact on maternal death and disability: family planning; attendance during childbirth by skilled health personnel, such as a midwife; and emergency obstetric care, in particular Caesarean sections.

9. The persistence of obstetric fistula in the developing world reflects not only health-care system constraints but also the broader economic and socio-cultural challenges facing women and girls. Poverty and gender inequality impede women's opportunities, including access to health services. Cultural constraints favouring

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[1] L. L. Wall et al., "The obstetric vesicovaginal fistula: characteristics of 899 patients from Jos, Nigeria", *American Journal of Obstetrics and Gynecology*, vol. 190, No. 4 (April 2004).

[2] *The Lancet*, vol. 368, issue 9542 (30 September 2006).

[3] See http://www.who.int/features/factfiles/obstetric_fistula/en/.

[4] M. C. Hogan, K. J. Foreman, M. Naghavi, S. Y. Ahn, M. Wang, S. M. Makela, A. D. Lopez, R. L. Lozano, C. J. Murray. "Maternal mortality for 181 countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5", *The Lancet*, vol. 375, issue 9726 (8 May 2010).

unassisted home delivery, including the use of traditional birth attendants, inhibit the utilization of maternal health services. The cost of health care can be financially prohibitive for poor and low-income families, especially when complications such as obstructed labour occur. In addition, lack of preparedness and deficiencies in other infrastructure, including in the areas of transport and communications, further compound the difficulty of accessing maternal and reproductive health services. These factors are involved in the three delays that impede women's access to health care: the delay in seeking care; the delay in arriving at a health-care facility; and the delay in receiving adequate care once at the facility.

10. Adolescent girls are particularly at risk for obstetric fistula and face a risk of maternal death two to five times greater than that faced by women in their twenties. There is evidence that delaying pregnancy until after adolescence may reduce the risk of obstructed labour and therefore of obstetric fistula. Sixteen million adolescent girls give birth each year, with almost 95 per cent of those births occurring in developing countries.[5] Malnutrition among girls may inhibit normal pelvic growth. Consequently, pregnancies that occur early, before the pelvis is fully developed, can increase the risk of obstructed labour. Generally, first-time births carry the greatest risk of obstetric fistula and require closer monitoring. Establishing positive habits among first-time mothers and their partners regarding delivery and birth-spacing choices is also likely to shape lifelong behaviours.

11. Socio-economic determinants such as child marriage also contribute to early pregnancy and childbearing, heightening the risk of obstetric fistula. Evidence demonstrates that impoverished, marginalized girls are more likely to marry as children and to give birth during adolescence than girls with greater economic and educational opportunities. Although age at marriage is rising in general, it is expected that more than 100 million girls in developing countries will be married before the age of 18 in the next decade.[6]

12. Reconstructive surgery can repair fistula injury; most women can be treated and, with appropriate psychosocial care, reintegrated into their communities. However, few health-care facilities are able to provide high-quality fistula treatment owing to the limited number of health-care professionals with the appropriate skills. In addition, even existing facilities suffer from a lack of health-care staff, equipment and medical supplies. Many women are not aware of, cannot afford and/or cannot reach the appropriate services even when they are available. Moreover, owing to the social and psychological consequences of living with obstetric fistula, women also need support in order to rebuild their self-esteem and to reintegrate into society, a process that includes appropriate counselling services, health education, literacy and vocational training.

13. As part of its commitment to universal access to reproductive health, in 2003, the United Nations Population Fund (UNFPA), with its partners, launched the global Campaign to End Fistula, with the objective of eliminating obstetric fistula by 2015.[7] The Campaign has helped to highlight the urgent need to reduce maternal mortality and morbidity so as to improve women's health. The Campaign is aimed not only at the achievement of Millennium Development Goal 5, but also at

[5] See http://www.who.int/making_pregnancy_safer.

[6] United Nations Population Fund, *Giving Girls Today and Tomorrow: Breaking the Cycle of Adolescent Pregnancy*, 2007.

[7] See http://www.endfistula.org/campaign_brief.htm.

complementing Goal 3, to empower women and to promote gender equality. The Campaign is now active in more than 47 countries, in Africa and Asia and among the Arab States. An International Obstetric Fistula Working Group, coordinated by UNFPA, also created in 2003, which comprises academic institutions, professional associations, faith-based organizations and health facilities, promotes the global coordination of the efforts made by the Campaign. It strives to ensure that the issue of obstetric fistula is situated in the context of efforts to reduce maternal mortality and morbidity and to generate a consensus and evidence regarding effective strategies for the treatment of fistula and the reintegration of women living with the condition. The Working Group has identified four major areas of work and established specific working groups on partnership and advocacy, data indicators and research, treatment and training, and reintegration.

III. Efforts at the intergovernmental and regional levels

A. Intergovernmental efforts

14. For two decades, the United Nations and the international community have campaigned to reduce maternal mortality and morbidity. Global commitments were first made at the 1987 International Safe Motherhood Conference, held in Nairobi. At the 1994 International Conference on Population and Development, held in Cairo, maternal health was recognized as a key component of sexual and reproductive health. In 1995, at the Fourth World Conference on Women, held in Beijing, Governments recognized that entrenched patterns of social and cultural discrimination were major contributors to sexual and reproductive ill-health, including maternal death and disability, along with lack of information and services. Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women requires States to ensure that women have appropriate services in connection with pregnancy, childbirth and the post-natal period. Article 24 of the Convention on the Rights of the Child also requires that States take adequate measures to ensure appropriate prenatal and post-natal health care for mothers.

15. In 2000, world leaders reaffirmed their commitments to improve maternal health through Millennium Development Goal 5, setting a target to reduce the maternal mortality ratio by two thirds by 2015 (see A/56/326). The same interventions that reduce mortality also prevent morbidities, including obstetric fistula. The subsequent addition of the target of universal access to reproductive health care under Goal 5 ensures full coverage of all factors necessary for improving maternal health. The other Goals, in particular Goals 3, 4 and 6, are closely related to women's health and survival. Currently, progress towards Goal 5 lags behind that made on all the other Goals, and efforts to achieve it have the lowest level of financial support. Of the 68 countries that account for most maternal and child deaths, only 16 per cent are on track to reach Goals 4 and 5 by 2015.[8]

16. The General Assembly first recognized the problem of obstetric fistula in 2005 in its resolution 60/141, entitled "The girl child", in which it urged States to promote gender equality and equal access to basic services in the areas of education, nutrition and health care, including sexual and reproductive health. It identified

[8] See http://www.thelancetglobalhealthnetwork.com/wp-content/uploads/2008/04/countdown.pdf.

early childbearing and limited access to sexual and reproductive health care as key factors in the persistence of obstetric fistula, maternal mortality and other morbidities.

17. In 2007, the Commission on the Status of Women focused on strategies for the elimination of all forms of discrimination and violence against the girl child. In the adopted agreed conclusions (see E/2007/27, chap. I, sect. A), among other things, it urged Governments to take the measures necessary to ensure the rights of the girl child in areas such as education and health, including reproductive health information and services. It also recognized the higher risk of obstetric fistula and maternal death among adolescents.

18. In 2008, for the first time, the General Assembly acknowledged obstetric fistula as a major issue in women's health by adopting resolution 63/158, entitled "Supporting efforts to eliminate obstetric fistula", which was sponsored by 138 Member States. In the resolution, the Assembly recognized the interlinkages between poverty, malnutrition, inadequate or inaccessible health-care services, early childbearing and child marriage as the main causes of obstetric fistula. It stressed the obligation of States to promote and protect all human rights and fundamental freedoms of women and girls. It further invited States to contribute to efforts to end obstetric fistula, including to the UNFPA-led global Campaign to End Fistula.

19. On the fifteenth anniversary of the Beijing Declaration and Platform for Action, the Commission on the Status of Women, at its fifty-fourth session, held in March 2010, adopted a resolution entitled "Eliminating preventable maternal mortality and morbidity through the empowerment of women". In the resolution, the Commission recognized the need for greater coordination, global cooperation and commitment to achieving universal access to health services for women and girls through a primary health-care approach and evidence-based interventions, including the provision of sexual and reproductive health-care services, including family planning, in line with the Beijing Platform for Action and the Cairo Programme of Action.

20. At its eleventh session, in June 2009, the Human Rights Council adopted resolution 11/8, entitled "Preventable maternal mortality and morbidity and human rights". In the resolution, the Council requested the Office of the United Nations High Commissioner for Human Rights to prepare a thematic study on preventable maternal mortality and human rights, in consultation with States, WHO, UNFPA, the United Nations Children's Fund (UNICEF), the World Bank and other relevant stakeholders. At its fourteenth session, in June 2010, the Human Rights Council considered the resulting study, which identifies the human rights dimensions of preventable maternal mortality and morbidity in the existing international framework. The study, endorsed by 108 countries, includes an overview of initiatives and activities undertaken within the United Nations system aimed at addressing the causes of preventable maternal mortality and morbidity and identifies ways in which the Council can add value to existing initiatives through a human rights analysis.

21. In 2009, members of the Partnership for Maternal, Newborn and Child Health[9] reached agreement on the Global Consensus on Maternal, Newborn and Child Health, with the aim of making every pregnancy wanted, every birth safe and every

[9] See http://www.who.int/pmnch/en/.

newborn and child healthy. The framework highlights the need to align actions in the areas of politics, finance, and delivery with a cohesive set of policies and priority interventions with regard to which stakeholders can take action.[10]

22. At the second Women Deliver conference, held in Washington D. C., in June 2010, more than 3,000 participants from all over the world gathered for a discussion on the theme "Delivering solutions for girls and women". Representatives of 115 countries, including ministers, first ladies and parliamentarians, came together to mobilize political and financial support for women's health, in particular to prevent maternal death and disability. They highlighted the fact that the Millennium Development Goals will not be achieved if there is no investment in women and girls, and stressed that maternal and reproductive health needs were a global priority. The conference ended with a Ministers' Forum statement acknowledging collective responsibility to improve the health of women and girls, especially in developing countries, and reconfirmed girls and women's health as a human right.[11]

B. Regional efforts

23. Concerned about the lack of progress on Goals 4 and 5, the African Regional Reproductive Health Task Force in 2003 called on African countries to develop a road map for accelerated maternal and newborn mortality reduction. The plan, endorsed by WHO, UNFPA, UNICEF, the World Bank and other partners, aims to help Governments plan and mobilize support for skilled attendance during pregnancy, childbirth and the post-natal period, at all levels of the health-care system, and to strengthen national health-care systems. To date, more than 40 African countries have developed road maps. Such plans contribute to progress in planning and programming, and it is expected that domestic and international financial support will lead to substantial progress in the area of maternal, newborn and child health.

24. Recognizing that African countries are less likely to achieve the Millennium Development Goals in the absence of significant improvements in the sexual and reproductive health of Africans, the second ordinary session of the Conference of African Ministers of Health, meeting in Gaborone in October 2005, adopted the Continental Policy Framework on Sexual and Reproductive Health and Rights, which was endorsed by African Union Heads of State in January 2006. The Framework, more popularly known as the Maputo Plan of Action, addresses the reproductive health and rights challenges faced by Africa and features a substantial component on obstetric fistula as part of a comprehensive reproductive health strategy. It calls for the strengthening of the health sector through increased resource allocations for health. It also addresses the mainstreaming of gender issues into socio-economic development programmes and sexual and reproductive health commodity security. The African Union Ministers of Health recommended that sexual and reproductive health be among the six highest priorities of the health sector.

25. At the Africa regional conference on fistula and maternal health held in Côte d'Ivoire in October 2008, participants from non-governmental organizations

[10] http://www.who.int/pmnch/topics/maternal/consensus_12_09.pdf.

[11] http://www.womendeliver.org/assets/Ministers_Forum.pdf.

launched an African regional network of civil society organizations with the overall aim of promoting South-South cooperation to advance the fistula and maternal health agenda. The network serves as a solid platform for leveraging technical and financial resources so as to effectively address the issue of obstetric fistula and promote maternal health.

26. The Campaign on Accelerated Reduction of Maternal Mortality in Africa is an initiative aimed at promoting and advocating the renewed and intensified implementation of the Maputo Plan of Action in Africa. UNFPA, UNICEF, WHO, bilateral donors and civil society organizations support the Campaign at the national, regional and global levels. The Campaign, which is a country undertaking, uses policy dialogue, advocacy and community mobilization to enlist political commitment, increase resources and effect societal change in support of maternal health. In July 2010, African Union Heads of State committed to launching the Campaign in all countries and broaden it as an advocacy strategy for the promotion of maternal, newborn and child health.

27. In Asia, the South Asian Association for Regional Cooperation (SAARC), under its 2005-2010 Development Goals, incorporated the issue of maternal health, focusing on reducing maternal mortality and improving nutritional standards for adolescent girls and pregnant women. Key targets include increased skilled birth attendance, pre- and post-natal care and a rapid decline in total fertility rates. SAARC has also initiated a regional maternal, newborn and child health project aimed at strengthening infrastructure; improving the skills and capacities of health-care providers; and improving referral transportation.

28. A Regional Network for Maternal and Neonatal Mortality and Morbidity Reduction is active in South Asia. Members of the Network include the United Nations system, non-governmental organizations, professional associations, regional development banks and SAARC. The Network has identified as priorities the strengthening of health-care systems, focusing on the health-care workforce; improving the quality of services; scaling up the number of community midwives; and demand creation linked to efforts to improve service affordability. Collective action is focused on advocating for skilled human resources for maternal, newborn and child health.

29. A Regional Inter-agency Task Force for the Reduction of Maternal Mortality was established almost a decade ago in the Latin American and Caribbean region to address regional challenges in the area of maternal mortality and morbidity reduction. Members include United Nations agencies, bilateral donors, development banks and non-governmental organizations. The Task Force meets regularly and is guided by an inter-agency strategic consensus developed in 2002. Current priorities include mobilizing political commitment; collecting and analysing data to demonstrate the extent of the problem and to identify the populations most affected; and capacity development in the strengthening of health-care systems.

IV. Recent actions taken by the international community and the United Nations

A. Data collection and analysis

30. In order to make data available, the Geneva Foundation for Medical Education and Research and WHO have developed a tool that allows for centralized data entry, analysis and comparison across sites. A compendium of indicators has been developed to assist countries in reinforcing their health information systems and to contribute to national household surveys in addressing the issue of obstetric fistula. In addition, a standardized fistula module for inclusion in country demographic health surveys and national health maternal information systems has been developed and used in the demographic health surveys of Nigeria (2008) and Kenya (2009).[12] In Nepal and Bangladesh, a system for the monitoring of obstetric fistula cases is being initiated, with the objective of finding unreported cases. The model offers an example of a public-private partnership in which private practitioners, gynaecologists and obstetricians serve as primary reporting units for their registration, notification and reporting of cases to the government. The government machinery then helps in the treatment, rehabilitation and reintegration of the persons concerned, with support from UNFPA.

31. As the issue of obstetric fistula becomes increasingly visible, countries are taking the initiative, often with support from the Campaign to End Fistula, to conduct national research and analyse national data. In 2008, seven countries made available data on fistula through national demographic health surveys reports. The Democratic Republic of the Congo, Ethiopia, Malawi, Mali, the Niger, Pakistan and Uganda all included fistula-related questions in their demographic health surveys to identify, among other things, the prevalence of and awareness of fistula. Maternal death and near-miss[13] reviews are increasingly recognized and utilized as a means of improving quality assurance. Reviewing the way in which cases of maternal death and severe complications are handled makes it possible to understand where the quality of care needs to be increased.

32. Conducted in partnership by UNFPA, UNICEF, WHO and the Averting Maternal Death and Disabilities Programme of Colombia University, New York, an increasing number of countries in Africa, Asia and Latin America are conducting emergency obstetric and newborn care needs assessments. The revised emergency obstetric and newborn care situation analysis tool, which includes an obstetric fistula module, has been utilized in countries such as Gabon, and it is envisioned that additional countries will use it to increase the availability of data on fistula and contribute to a more comprehensive understanding of maternal health.

33. Accurately reflecting the magnitude of the problem of obstetric fistula is an important step towards eliminating it. Johns Hopkins University, UNFPA and WHO, in collaboration with medical and national institutions in several countries, are conducting a multi-centric study aimed at examining the links between surgical prognosis and treatment and long-term health, psychosocial status and reintegration

[12] http://www.measuredhs.com/aboutsurveys/search/listmodules_main.cfm.

[13] A near miss is understood as a severe, life-threatening obstetric complication necessitating urgent medical intervention in order to prevent the likely death of the mother (WHO, *Beyond the numbers*, 2004).

outcome following surgery. The results of the study will help develop a prognostic-based classification system for obstetric fistula, guide advocacy and devise appropriate, cost-effective, feasible programmes and national strategies.

34. In 2009, a midterm evaluation of the Campaign was conducted by UNFPA with the aim of taking stock of the progress made since its launch in 2003. Particular emphasis was placed on the effectiveness and efficiency of programmes at the national, regional and global levels. The exercise culminated in constructive recommendations for action at all three levels and strongly called for increased technical assistance to countries; the promotion of family planning and maternal health as part of a broader prevention strategy; improving the quality of treatment services; advocacy of awareness-raising programmes and social change; the promotion of monitoring and evaluation; and enhanced resource mobilization at the global and national levels.

B. Prevention strategies and interventions to achieve maternal health goals and eliminate obstetric fistula

35. The factors that lead women to develop obstetric fistula are the same as those that cause maternal morbidity and mortality. Obstetric fistula can be prevented as part of the efforts made to achieve Millennium Development Goal 5, through universal access to high-quality and accessible reproductive health services with the potential for immediate impact, such as family planning, skilled birth attendance and emergency obstetric care.

36. Access to family planning ensures that every pregnancy is wanted and helps prevent a recurrence of obstetric fistula during future pregnancies of fistula victims. Estimates indicate that 137 million women around the world still have an unmet need for contraception. In sub-Saharan Africa, the contraceptive prevalence rate remains under 20 per cent, while the unmet need stands at 27 per cent. In order to help meet the unmet need for family planning, in particular in isolated areas, many countries have enlisted community health workers to provide primary care, including family planning education and services at the community level.

37. The likelihood of the prevention of death or disability during labour and delivery is greatly increased by the presence of a skilled professional such as a midwife. In regions with high maternal mortality and morbidity rates, the proportion of births attended by a skilled professional averaged 47 per cent, with extremes of 7 per cent, as is the case in Ethiopia. The detection of obstructed labour and access to Caesarean section are crucial in the prevention of obstetric fistula. This is possible if it is ensured that women have access to basic emergency obstetric and newborn care at birth and to comprehensive emergency obstetric care when complications arise. In 2008, UNFPA, in collaboration with the International Confederation of Midwives, launched the Midwives Programme, with the goal of improving skilled attendance at birth in low-resource settings by developing the foundations of a sustainable midwifery workforce. By the end of 2009, the Programme was active in 15 countries, mainly in Africa and among the Arab States, and in a few countries in Latin America. Plans are under way to expand to another six to eight countries in Asia and Africa in 2010.[14]

[14] UNFPA, *Annual Report 2009 — Campaign to End Fistula.*

38. Access to services is the greatest challenge in the prevention of maternal mortality and morbidity. The findings of the emergency obstetric care needs assessments are used as a basis for regional and district-level planning for improving access to quality maternity services. In Eritrea, maternity waiting homes were used as a key strategy for bridging the geographical "gap" in access to obstetric care. In Guinea-Bissau, intensive efforts are being made to decentralize maternal health services by reinforcing health centres in emergency obstetric and newborn care and by subsidizing Caesarean section kits for marginalized and poor communities. In order to increase the geographical distribution of emergency obstetric and newborn care services in Somalia, UNFPA, in the very difficult context of civil war, provided support to its implementing partners for the conduct of an 18-month training course for 20 community midwives selected from remote districts.

39. As cost or a user fee is a serious barrier to access to and utilization of prevention services, some countries have taken serious steps with respect to the practice of charging user fees at the time of service. In several countries in Africa and Asia, no user fees are charged for emergency obstetric and newborn care services. In India, UNFPA has helped establish a conditional cash transfer programme under which women receive cash for delivering in a facility, while in Bangladesh, the Government and UNFPA are piloting a voucher scheme that is encouraging more women to take advantage of early antenatal care and delivery services.

40. Strengthening referral systems is an important step in the prevention of obstetric fistula, through the provision of means of transport for women to obtain easy and quick referrals. In many countries, UNFPA and its partners supported communities through the provision of transport by ambulance and motorbike, including in Benin, Chad, Guinea, Guinea-Bissau, Kenya, Rwanda, Senegal, Uganda, the United Republic of Tanzania and Zambia.

41. In 2008, UNFPA, WHO, UNICEF and the World Bank came together as four partners, Health 4, with the objective of harmonizing and enhancing support for developing countries in reducing maternal mortality and achieving universal access to reproductive health. A joint statement on maternal, newborn and child health was signed by principals of the four agencies. The members of Health 4 have committed to working together in the 60 countries with the highest maternal mortality ratio of more than 300 for every 100,000 live births, starting with 25 priority countries in 2009-2010. The Health 4 agencies work with partners and provide coordinated support at the country level for the strengthening of national health-care plans. Coordination is guided on the basis of a continuum of care and support for national health-care plans, drawing on each agency's strengths, assigning key responsibilities and promoting effective mechanisms for country-level coordination.

42. Community-based intervention and communication help to increase awareness about overcoming the barriers to educating the community about obstetric fistula prevention and to identify solutions that are culturally accepted. Over the last few years, one of the most innovative and successful approaches has been the involvement of fistula survivors in community mobilization. Eighteen Campaign countries supported fistula survivors in their efforts to sensitize communities, provide peer support and advocate improved maternal health at both the community and national levels. The work of fistula survivors is expanding in terms of both the

number of countries working in this area and the level of engagement of the survivors. For example, in Ghana, 18 fistula survivors received training in personal leadership, the prevention and treatment of obstetric fistula, rehabilitation and reintegration, advocacy, communication, power mapping and counselling skills, after which each woman developed an action plan detailing her community-level activities. In Zambia, the UNFPA Country Office supported the orientation and recruitment of community mobilizers such as safe motherhood action groups, peer educators and counsellors, and other community-based groups towards galvanizing communities to work towards improving their reproductive health conditions and the status of women.

43. For responses to the problem of maternal death and disability to be effective, it is vital to address its socio-economic and cultural determinants. Many women in labour do not deliver in medical facilities but prefer home deliveries without trained medical supervision, owing to strong socio-cultural and economic pressures. It is essential that procedures be put in place involving the community through which women in prolonged labour can be brought without delay to adequate facilities for delivery. A community project undertaken in the Niger has shown significant improvement in reproductive health indicators and in the prevention of obstetric fistula. Within four months of the introduction of the project, in February 2008, obstructed-labour deaths were eliminated in the target areas. The rate of obstetric fistula was reduced; no new fistula cases had occurred for more than 10 months as of June 2010. In addition, medical records show that prenatal consultations are up 63 per cent and births in health settings are up 70 per cent.[15]

44. The education and empowerment of women is crucial in the prevention of obstetric fistula. Educated women better understand the need for appropriate care during pregnancy and delivery. They are more prepared to delay marriage, prevent early pregnancies and act upon their reproductive health choices. Investing in women, promoting girls' education and ending child marriage are some of the main issues that are critical to ending obstetric fistula.

45. In 2007, an Inter-Agency Task Force on Adolescent Girls[16] was established to support Governments in investing in adolescent girls as a strategy for poverty reduction, the prevention of child marriage, the reduction of maternal mortality and morbidity and the promotion of adolescent health, including sexual and reproductive health. In March 2010, the Task Force signed a joint statement pledging to intensify efforts to fulfil the human rights of adolescent girls by increasing support to developing countries so as to advance key policies and programmes aimed at empowering the hardest-to-reach adolescent girls.[17]

46. Countries around the world are reinforcing a policy environment that is conducive to the protection of women and girls. In Pakistan, initiatives have been taken that are aimed at promoting the Women's Protection Bill. UNFPA is working in close partnership with selected civil society organizations and women's groups in their ongoing campaigns to highlight harmful traditional practices, including child marriage, through the media, advocacy and dialogue. In Ethiopia, the early marriage

[15] See www.hdi-us.org.

[16] UNFPA, UNICEF, the International Labour Organization, the United Nations Development Fund for Women, UNESCO and WHO.

[17] See http://www.unfpa.org/webdav/site/global/shared/documents/news/2010/joint_statement_adolescentgirls.pdf.

programme, which focuses on adolescent girls and the general community in Amhara state, has made tangible contributions towards delaying adolescent marriage and improving the reproductive health status of girls in the context of a more comprehensive approach.

C. Treatment strategies and interventions

47. For women suffering from obstetric fistula, treatment represents hope for a new life. Although prevention is the ultimate means of eliminating obstetric fistula, treatment is critically important for women living with the condition. Countries have embarked on efforts to increase access to obstetric fistula treatment through the upgrading of health facilities and the training of health personnel. Since the launch of the Campaign to End Fistula, support has been provided to 47 countries, resulting in fistula treatment and care for an estimated 16,000 women and the training of thousands of health-care personnel in fistula prevention and management.

48. Many countries have registered an increase in treatment capacity; for example, in the Democratic Republic of the Congo, more than twice as many women received treatment in 2009 as did in 2008. In Eritrea, the Federal Government announced its commitment to eliminating obstetric fistula in the country by the end of 2011. The Campaign supported an outreach programme for women in Ghana living with obstetric fistula to ensure that they were registered with the national health insurance scheme and could receive treatment without having to bear the burden of the cost. Such increases in capacity and in the provision of care are encouraging. However, owing to the fact that treatment capacities are not sufficient to serve all new cases, a tremendous backlog of patients remains. A dramatic and sustainable scale-up of existing treatment approaches is needed. This is an important challenge that countries and the Campaign to eliminate obstetric fistula will face in the coming years.

49. South-South collaboration is a key aspect of the Campaign's approach. With UNFPA support, health providers and civil society organizations have travelled from Nigeria to the Sudan, from Ethiopia to the Niger, from Mali to Cameroon and to additional countries to exchange experiences and advance innovative programming. To train human resources, senior gynaecologists from the Dhaka Medical College Hospital in Bangladesh have been training medical professionals in Afghanistan. The Campaign will continue to further facilitate and develop efforts to connect countries with the aim of enabling them to share and learn from one another. There are numerous instances of North-South collaboration with organizations and academia that make significant contributions to capacity-building, including the collaboration between Benin and the Geneva Foundation for Medical Education and Research, between the Democratic Republic of the Congo and Doctors without Borders, between Mauritania and Equilibres et Populations, and the long-standing collaboration between Eritrea and Stanford University, United States of America.

50. To improve the quality of care and ensure that all women receive the best treatment possible, many actions have been undertaken by United Nations agencies, Governments and partners, as well as surgeons. The International Federation of Gynaecology and Obstetrics has developed a competency-based training curriculum on obstetric fistula that is aimed at harmonizing surgical approaches and techniques among fistula centres. WHO elaborated the guiding principles for clinical management and programme development, a practical guide that provides essential

background information along with principles for developing fistula prevention and treatment strategies and programmes. The International Society of Obstetric Fistula Surgeons was created in 2008, with the aim of reinforcing knowledge-sharing, the harmonization of practices and the quality of care, as well as support for professionals. The Bangladesh National Fistula Committee, established in 2009, brings together the Government, UNFPA, EngenderHealth and 14 medical college hospitals.

D. Reintegration strategies and interventions

51. Healing fistula requires not only surgical intervention but also psychosocial and economic support. About one quarter of Campaign countries have established reintegration programmes, with more to follow in 2010. A number of countries, including the Niger and Senegal, have substantially increased access to reintegration services, from one to four sites in the former and one to five sites in the latter. In most countries, reintegration services include counselling, reproductive health education, family planning services and income-generating activities, combined with community sensitization so as to reduce stigma and discrimination.

52. Making fistula treatment available free of charge and making funding available for reintegration increases the utilization of such services. The majority of Campaign countries reported that cost was an important factor in the delivery of fistula treatment and care. When treatment cost was removed from the equation through subsidized care or insurance coverage, more women sought treatment. There is an ongoing need for committed donor support to provide the resources necessary to implement the lessons learned. Multi-year commitments are particularly important to help ensure sustainable and continued programming.

53. In 2009, at least six countries — Bangladesh, Burkina Faso, Côte d'Ivoire, Chad, Liberia, and the Niger — reported on the number of treated women who received social reintegration and rehabilitation services. This is indicative of the increased attention given to the delivery of reintegration and rehabilitation services and also to the move towards increased data collection with respect to this important component of the continuum of care. Côte d'Ivoire reported that 27 of 119 women who had received treatment in 2009 had been fully reintegrated into their communities. Such data must be considered with the awareness that not all women receive such services after treatment. Prior to 2010, very few countries reported the percentage of treated women who received reintegration and rehabilitation services, and this information can therefore be utilized as a baseline for the countries reporting.

E. Advocacy and awareness-raising

54. Efforts by the Campaign and the Partnerships and Advocacy Committee of the International Obstetric Fistula Working Group have helped raise global and national awareness, muster political will and promote increased knowledge and understanding about the issue of obstetric fistula. They have targeted a variety of audiences in donor and developing countries, including policymakers, community and religious leaders, service providers, administrative officers and government officials. As a result, significant interest has continued to be evinced on the part of

various partners, including donor governments, national and international non-governmental organizations and the private sector.

55. An increasing number of partners within the Campaign are supporting the participation of women who have lived with obstetric fistula in advocacy efforts to end the problem. More and more former fistula patients are playing an important role by working as community advocates and raising national and global awareness of the right to treatment and the importance of funding obstetric fistula programmes as part of a wider strategy to prevent maternal death and disability.

56. The Campaign has also helped draw attention to systemic weaknesses in health-care systems that lead to maternal deaths and disability and to the need to address a reproductive health strategy in a holistic manner. In several countries, advocacy, community mobilization, sensitization and awareness-raising activities around the issue of obstetric fistula have contributed to increased knowledge and understanding of maternal health issues. The integration of the issue into national policies has been essential in the process of securing the political and financial commitment necessary to end the problem. Currently, more than 28 countries have integrated the issue of obstetric fistula into national health-care policies and programmes. In 2009, Malawi integrated the issue into its newly revised national reproductive health policy, thereby increasing opportunities for national resource mobilization.

57. Advocacy and communication for development initiatives, through documentaries, television programmes and radio interviews, have been used to raise awareness about obstetric fistula and maternal-health-related issues in several countries in Africa and Asia. Between 2008 and 2010, numerous articles, news stories and documentaries highlighting related activities in the field have been produced and used in countries to generate discussion on fistula and maternal health. At the national level, awareness-raising and community-mobilization efforts within communities are frequently carried out by local civil society organizations, including non-governmental organizations.

F. Global support and resource mobilization

58. Significant global momentum now exists to address the issue of maternal health within the context of the Millennium Development Goals. Several global initiatives are under way to support the achievement of the health-related Goals; some are groups of international health organizations lobbying for high-level political advocacy, others are alliances of international non-governmental organizations and United Nations agencies working to coordinate interventions. One example is the Global Consensus on Maternal, Newborn and Child Health. More recently, the United Nations initiated a global effort on women's and children's health that will build upon and revitalize existing strategies and commitments and secure new commitments from a range of partners.

59. Since 2003, the Campaign has grown from 12 countries to more than 47, in Africa, Asia, and among the Arab States. Since then, contributions of more than $38 million[18] have been made to the Campaign by Governments, international

[18] The figure is based on contributions received for the largest programmes of the Campaign and does not account for all funding.

financial institutions and the private sector, including individual donors, to support activities aimed at ending obstetric fistula.

60. The leaders of 12 international health-related agencies have formed the International Health Partnership and related initiatives, aimed at improving health by coordinating donor countries and other development partners around a single country-led national health strategy. Founded in 2007, the Partnership is guided by the principles of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, which recognizes the need to strengthen health-care systems and support one national process in the health sector.[19]

61. In 2008, the heads of eight health-related organizations formed an informal group to collaborate on the strengthening of global public health-care systems through coordinated teamwork, joint priority-setting and the recognition that both civil society and the private sector play a critical role in supporting and strengthening country health-care systems. The group, known as the Health Eight, which comprises WHO, UNFPA, UNICEF, the Joint United Nations Programme on HIV/AIDS, the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance and the Bill and Melinda Gates Foundation, meets every six months to strengthen collaboration and escalate global efforts to reach the health-related Millennium Development Goals.

62. Several new funding commitments in support of maternal health that also support fistula programming have recently been announced, including a commitment made by the Bill and Melinda Gates Foundation in June 2010 to invest $1.5 billion in new support for integrated women's and children's programmes over the next five years. Furthermore, the Government of Canada, at the Group of Eight Summit in June 2010, announced that its total contribution for maternal, newborn and child health would be $2.85 billion over five years, which includes $1.1 billion in new funds.

63. The High-level Taskforce on Innovative International Financing for Health Systems was established in September 2008 to help strengthen the health systems of the world's poorest 49 countries by exploring and recommending actions to protect social-sector investments and strengthen international assistance. The Taskforce, which differs from entities that address the issue of aid efficiency, such as the Health 4 and the International Health Partnership and related initiatives, aims to help catalyse a significant increase in donor resources.

64. In January 2008, UNFPA established the Maternal Health Thematic Fund. The Fund has raised nearly $50 million to date to support those countries with the highest maternal mortality rate and is now active in 27 countries. The goal of the Fund is to increase the capacity of health-care systems so as to enable them to provide a continuum of quality maternal health-care services, strengthen mechanisms aimed at reducing health-care inequities and empower communities to exercise their rights to reproductive health. The Thematic Fund contributes to both the Campaign to End Fistula and the Midwifery Programme. The strengthening of the programme on midwifery is also key to preventing obstetric fistula.

[19] See http://www.internationalhealthpartnership.net/en/home.

V. Conclusion and recommendations

65. Over the past two years, considerable progress has been achieved in focusing attention on the issue of maternal death and disability and in addressing that of obstetric fistula. This is due mainly to the greater availability of evidence relating to effective interventions, enhanced data collection and analysis, advocacy programmes, partnerships, and subsequently stronger political and financial commitments. Obstetric fistula occurs because health-care systems fail to provide accessible, high-quality maternal health care, including family planning, skilled birth attendance and basic emergency obstetric care. There is now a greater understanding of the social and economic burden that results from poor reproductive and maternal health and its relation to poverty eradication, and a consensus on the key interventions necessary to reduce the rate of maternal death and disability, including obstetric fistula. Countries are increasingly investing in and promoting prevention, treatment and reintegration services for women living with obstetric fistula as part of efforts to achieve Millennium Development Goal 5.

66. In addition, multisectoral approaches have been undertaken in many areas aimed at drawing attention to the linkages between poverty, income inequalities, gender disparities, discrimination and poor education, as these factors contribute to poor health in women and girls. Hence, efforts to improve women's health should include the education of women and girls, economic empowerment, including access to microcredit and microfinance, and legal reforms and social initiatives aimed at delaying marriage and pregnancy.

67. Despite the fact that some positive developments have been achieved, many serious challenges remain. The struggle to improve health-care systems and reduce the rate of maternal mortality and morbidity, including obstetric fistula, must not only continue but intensify, as recently published estimates show that the progress made in maternal mortality reduction has been slow.[4] There is an urgent need to scale up well-known, cost-effective interventions so as to reduce the high number of avoidable maternal deaths and disabilities.

68. The specific actions must be taken to improve maternal health and to address the issue of obstetric fistula include:

(a) A greater investment in health-care systems, with an emphasis on trained and skilled human resources to promote maternal health, imorove health-care services and ensure that women and girls have access to the full continuum of reproductive health care and services, in particular family planning, skilled delivery care and emergency obstetric care. The continuum of care should cover the period from adolescence through pre-pregnancy, pregnancy, childbirth and the post-natal period;

(b) Efforts focused on supporting national plans aimed at strengthening health-care systems and identifying and addressing the underlying social, cultural and economic determinants of maternal death and disability. Special attention should be paid to areas with the highest maternal mortality and morbidity, particularly in sub-Saharan Africa and South Asia. Within countries, approaches must include efforts to reach poor populations and adolescent girls;

(c) **Investments aimed at supporting national health-care plans and addressing health-care coverage inequalities among various socio-economic and age groups, in particular in rural areas and in poor urban areas. Priorities must include ensuring access to a range of contraceptive methods in health-care facilities, appropriate plans to train, recruit and deploy human resources for maternal health, especially skilled birth attendants and midwives, and appropriate investments in infrastructure, equipment and supply chains to ensure provision of emergency obstetric care. These must be linked to other health issues that contribute to high rates of maternal mortality and morbidity, such as poor nutrition, HIV/AIDS and malaria;**

(d) **The strengthening of referral services and centres for the timely prevention of obstetric fistula and the implementation of well-funded national maternal health and obstetric fistula programmes. In addition, other specialized and decentralized services are necessary to meet the needs of women with fistula in all regions. This should be accompanied by the establishment of quality control and improved monitoring. Other mechanisms such as outreach service campaigns should be utilized until care and services can be provided routinely to help reduce the backlog of women awaiting treatment. Additionally, linkages with civil society organizations and women's empowerment programmes should be developed so as to ensure access to social reintegration support, including counselling, literacy and health education, skills development and income-generating activities;**

(e) **Making maternal health services and obstetric fistula treatment geographically and financially accessible and culturally acceptable. Geographic access requires the adequate distribution of health-care facilities and personnel, collaboration with the transport sector to ensure affordable transport options, and the promotion of community-based solutions. Financial access requires innovative mechanisms to ensure that delivery care and obstetric fistula treatment at delivery points are free or appropriately subsidized for women who cannot afford such services. Service delivery should take into account the specific needs of the population;**

(f) **The mobilization of communities so that they are involved, informed and empowered with respect to maternal health needs, utilize the relevant services and support women in accessing such services. Civil society organizations can play a role in working with communities. Women who have lived with obstetric fistula, as survivors of obstetric complications, should be empowered to contribute to such efforts. Men and boys in particular need to be involved in advocating the provision of services and supporting access by women to such services;**

(g) **Strengthened and expanded interventions to keep adolescent girls in school, stop child marriages and promote gender equality and positive health-seeking behaviours. Laws prohibiting child marriage must be adopted and enforced, and followed by innovative incentives for families to delay marriage. Programmes for adolescent girls that provide comprehensive life skills, including reproductive health information, need to reach those populations at greatest risk of child marriage and adolescent pregnancy. Reproductive health education programmes in schools need to be maintained to ensure that young people have the information and skills to protect their own health;**

(h) **Stronger research, monitoring and evaluation to guide the implementation of maternal health programmes. Countries should have monitoring and evaluation systems, including a community-based system for the notification of obstetric fistula cases and maternal and newborn deaths. Research that addresses the determinants and consequences of maternal death and disability, including research on the quality-of-life consequences of maternal morbidities such as obstetric fistula, is important and requires support;**

(i) **Partnerships and coordination of efforts among a variety of stakeholders at the local, national, regional and global levels need to be maintained so as to address the multifaceted determinants of maternal mortality and morbidity.**

69. **The challenge of putting an end to obstetric fistula requires intensified efforts at the national, regional and international levels. Such efforts must be part of a strengthening of health-care systems aimed at achieving Millennium Development Goal 5. If Goal 5 is to be achieved, additional resources must be forthcoming. To support priority countries, at least $1.2 billion per year for family planning and $6 billion annually for maternal health care could be required, including for the prevention of obstetric fistula. An estimated $750 million is needed to treat existing and new cases of obstetric fistula between now and 2015, assuming a decline in the number of new cases each year. The funding needs to be predictable and sustained. Continued support should be provided to countries' national plans, United Nations entities, including the Global Campaign to End Fistula, and the Maternal Health Thematic Fund, and other global initiatives dedicated to achieving Millennium Development Goal 5.**